Bell Pharmacy

Asthma Enrollment Form

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PATIENT INFORMATION

Name:	Date of Birth:		O Male O Female
Address:	City:	State:	Zip:
Phone:	Alt Phone:		Email:
SS #:	Primary Language:		Emergency Contact:

PRESCRIBER INFORMATION

Prescribing Practitioner:				NPI#:
Supervising Physician:				NPI#:
Address:	City:	State:	Zip:	Tax ID:
Phone:	Fax:			Office Contact:

MEDICAL INFORMATION

** PLEASE FAX COPY OF PRESCRIPTION MEDICATION/MEDICAL CARD, FRONT AND BACK, AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY **

O ICD-10 Code & Description: ______________________________

Patient Evaluation:

Height:__________________ in/cm Weight: __________________ kg/lbs

Allergies: ______________________________

Eosinophils: ______________________________

Steroid Dependant: O Yes O No

PRESCRIPTION INFORMATION

Needs by Date: Ship to: O Patients home O Prescriber 1st order only O Prescriber all orders O Other

Drug	Dose	Directions	Quantity	Refills
O Cinqair	100mg/10ml vial	Inject 3 mg/kg once every 4 weeks by IV infusion over 20 to 50 minutes. O Include sodium chloride and supplies sufficient for medication days supply. O IV administraion/infusion set (0.2 micron filter) O IV Cath Insyte autoguard or PIV insertion kit O Ultrasyte needle-free connector (one per vial shipped) O 30 mL syringe (one per vial shipped) O 50 mL 0.9% NaCl O 2 - 10 mL 0.9% NaCl flush O Alcohol swaps	Dispense: __________ 100mg vials (100mg/10mL)	O 12 months O
O EpiPen®		Use as directed.	1	
O EpiPen® Jr.		Use as directed.	1	
O Dupixent®	O 300mg/2mL PFS O 200mg/1.14mL PFS	O Two (2) Pens. Initial dose, then one (1) Pen every other week O One (1) Pen every other week	1	
O Fasenra® (benralizumab)	O 30mg/mL PFS O 30mg/mL autoinjector	O Inject 30mg subcutaneously every 4 weeks for 3 doses, followed by once every 8 weeks thereafter O Inject 30mg subcutaneously every 8 weeks		
O Nucala	O 100mg vial O 100mg/mL autoinjector O 100mg/mL PFS	O Severe asthma in patients aged 12 years and older: 100mg administered subcutaneously once every 4 weeks O Severe asthma in patients aged 6 to 11 years: 40mg administered subcutaneously once every 4 weeks		

INJECTION TRAINING

O Patient has received pen & injection training O Physician's office to provide injection training O Parkway Pharmacy to coordinate injection training

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing Parkway Pharmacy to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.

Prescribing Practitioner Date

CONFIDENTIALITY NOTICE

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Faxed Prescriptions will only be accepted from a prescribing practitioner.